



TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

**Certified Peer Recovery Specialist
Renewal Application**

Type or write legibly in only black or blue ink. Renewal Applications are due fourteen (14) calendar days prior to the recertification deadline. Fax the completed Renewal Application and accompanying continuing education certificates to 615-253-3920.

Name _____ Date _____

Certification Number _____ Certification Date _____

Address _____

City, State, ZIP _____

Phone (with area code) _____

Email (required) _____

Social Security Number _____

Continuing Education

Ten (10) hours of continuing education are required annually to maintain certification and must be earned within the certification period. Refer to Section VI, Continuing Education Guidelines, of the CPRS Handbook of Guidelines, Standards, and Procedures for continuing education requirements. For each training, include a copy of the certificate of attendance or completion. Note: TDMHSAS-approved on-line trainings are limited to five (5) hours out of the 10 hours required, and a minimum of one (1) hour of continuing education per year must be in ethics.

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Title of Training _____ Number of Hours _____

Total Number of Hours _____

My signature below affirms that all of the information contained in this application is true and correct to the best of my knowledge and has been completed by no other person. I understand that knowingly providing false information shall be grounds to deny or revoke my certification.

Your signature _____ Date _____

Your printed name _____

Employment/Volunteer Service Summary

This section is to be completed by the supervising behavioral health professional. All Certified Peer Recovery Specialists must be under the general supervision of a behavioral health professional in accordance with acceptable guidelines and standards of practice by the State and as defined in the TDMHSAS Licensure rules, Chapter 0940-05-01.

Supervisor _____ Credentials _____

Title _____

Agency/Organization _____

Address _____

City, State, ZIP _____

Phone (with area code) _____

Email _____

CPRS's position within the agency _____

Number of hours per week (work or volunteer service) _____

My signature below affirms that all of the information contained in this document is true.

Signature of Supervisor _____ Date _____